Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DALLAS
3255 W PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name
Dallas ISD

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0097-01

MFDR Date Received
September 12, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medicare would have allowed this facility $973.63 for the MAR @ 200% and $2,800.90 per the OUTLIER calculations."

Amount in Dispute: $3805.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Medicare did not apply an outlier amount to any of the billed codes. Therefore, the prior reimbursement amount of $10,676.64 (5,338.32 x 200%) is correct."

Response Submitted by: Argus Services Corporation, 811 S. Central Expwy • Suite 440 • Richardson, Texas 75080

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, through March 11, 2012	Outpatient Hospital Services	$3,805.21	$176.26

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 11, 2012

   - 97H – The benefit for this service is included in the payment/allowance for another service/procedure that

has already been adjudicated. “Service(s)/Procedure is included in the value of another service/procedure billed on the same date.”

- W1TA – Workers Compensation State Fee Schedule Adjustment. “Medicare outpatient hospital specific reimbursement amount multiplied by 200%. DWC rule 134.403.”

Explanation of benefits dated August 13, 2012

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 97H – The benefit for this service is included in the payment(s) allowance for another service/procedure that has already been adjudicated. “Service(s)/Procedure is included in the value of another service/procedure billed on the same date.”
- 193W – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly “Previous recommendation was in accordance with the Workers’ Compensation State Fee Schedule.”
- W1TA – Workers Compensation State Fee Schedule Adjustment. “Medicare outpatient hospital specific reimbursement amount multiplied by 200%. DWC rule 134.403.”

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code C1713 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code C1762 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 80048, date of service February 27, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.91. 125% of this amount is $14.89
   - Procedure code 85025, date of service February 27, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the

service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $10.94. 125% of this amount is $13.68

- Procedure code 85610, date of service February 27, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.53. 125% of this amount is $6.91
- Procedure code 78452, date of service February 29, 2012, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0377, which, per OPPS Addendum A, has a payment rate of $673.07. This amount multiplied by 60% yields an unadjusted labor-related amount of $403.84. This amount multiplied by the annual wage index for this facility of 0.965 yields an adjusted labor-related amount of $389.71. The non-labor related portion is 40% of the APC rate or $269.23. The sum of the labor and non-labor related amounts is $658.94. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $658.94 divided by the sum of all S and T APC payments of $5,049.56 gives an APC payment ratio for this line of 0.130495, multiplied by the sum of all S and T line charges of $16,461.75, yields a new charge amount of $2,148.18 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $658.94. This amount multiplied by 200% yields a MAR of $1,317.88.
- Procedure code A9502, date of service February 29, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 27696 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0050, which, per OPPS Addendum A, has a payment rate of $2,268.99. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,361.39. This amount multiplied by the annual wage index for this facility of 0.965 yields an adjusted labor-related amount of $1,313.74. The non-labor related portion is 40% of the APC rate or $907.60. The sum of the labor and non-labor related amounts is $2,221.34. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,110.67 divided by the sum of all S and T APC payments of $5,049.56 gives an APC payment ratio for this line of 0.219954, multiplied by the sum of all S and T line charges of $16,461.75, yields a new charge amount of $3,620.83 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $1,110.67. This amount multiplied by 200% yields a MAR of $2,221.34.
- Procedure code 27691 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0051, which, per OPPS Addendum A, has a payment rate of $3,323.53. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,994.12. This amount multiplied by the annual wage index for this facility of 0.965 yields an adjusted labor-related amount of $1,924.33. The non-labor related portion is 40% of the APC rate or $1,329.41. The sum of the labor and non-labor related amounts is $3,253.74. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the

line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $3,253.74 divided by the sum of all S and T APC payments of $5,049.56 gives an APC payment ratio for this line of 0.644361, multiplied by the sum of all S and T line charges of $16,461.75, yields a new charge amount of $10,607.31 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,900, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.262. This ratio multiplied by the billed charge of $10,607.31 yields a cost of $2,779.12. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $3,253.74 divided by the sum of all APC payments is 61.66%. The sum of all packaged costs is $4,392.09. The allocated portion of packaged costs is $2,708.17. This amount added to the service cost yields a total cost of $5,487.29. The cost of these services exceeds the annual fixed-dollar threshold of $1,900. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $3,253.74. This amount multiplied by 200% yields a MAR of $6,507.48.

- Procedure code 97001, date of service March 9, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $74.13. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $119.48
- Procedure code 97116 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $27.52. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $44.36
- Procedure code 97116, date of service March 9, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $20.64. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $33.27
- Procedure code 97116, date of service March 10, 2012, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c). The fee listed for this code in the Medicare Physician Fee Schedule is $20.64. This amount multiplied by 2 units is $41.28. This amount divided by the Medicare conversion factor of 34.0376 and multiplied by the Division conversion factor of 54.86 yields a MAR of $66.53
- Procedure code 97530, date of service March 10, 2012, is unbundled. This procedure is a component service of procedure code 97530 performed on the same date. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment is not recommended.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 94760, date of service March 9, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93017, date of service February 29, 2012, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0100, which, per OPPS Addendum A, has a payment rate of $178.37. This amount multiplied by 60% yields

an unadjusted labor-related amount of $107.02. This amount multiplied by the annual wage index for this facility of 0.965 yields an adjusted labor-related amount of $103.27. The non-labor related portion is 40% of the APC rate or $71.35. The sum of the labor and non-labor related amounts is $174.62. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $174.62. This amount multiplied by 200% yields a MAR of $349.24.

- Procedure code 99201, date of service February 27, 2012, has a status indicator of V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0604, which, per OPPS Addendum A, has a payment rate of $53.84. This amount multiplied by 60% yields an unadjusted labor-related amount of $32.30. This amount multiplied by the annual wage index for this facility of 0.965 yields an adjusted labor-related amount of $31.17. The non-labor related portion is 40% of the APC rate or $21.54. The sum of the labor and non-labor related amounts is $52.71. The cost of these services does not exceed the annual fixed-dollar threshold of $1,900. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $52.71. This amount multiplied by 200% yields a MAR of $105.42.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690, date of service March 9, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1650, date of service March 9, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1650, date of service March 10, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1650, date of service March 11, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405, date of service March 10, 2012, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. The total allowable reimbursement for the services in dispute is $10,852.90. This amount less the amount previously paid by the insurance carrier of $10,676.64 leaves an amount due to the requestor of $176.26. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $176.26.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $176.26, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 26, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.